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The Development of Phobias in Married Women[1]

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I. INTRODUCTION

In considering the etiology, status, and consequents of abnormal fear reactions there is not only a dearth of experimental data, but also lack of clarity in use of the terms involved. Generally, abnormal fear reactions are briefly mentioned in passing as being self-evident. Few hypotheses regarding causal factors and their methods of combination have been attempted. Few of the results of studies concerning phobias seem to be objectively verifiable. Lack of clear, certain knowledge of the phobias seems particularly regrettable, since phobias are generally considered to be a link between the neuroses and the psychoses.

It is hoped that the results of this study may cast some light upon the etiological factors involved in the development of the phobic syndrome.

II. METHODS AND PROCEDURE

A. General Approach to the Problem

In beginning a discussion of the problem, of first importance is the matter of determining a practicable method for dealing with phobic patients. In this instance, the case study method was chosen. Our purpose is to seek by careful inspection those factors which seem etiologically significant in the patient's life history, or at least to see if any threads of commonality recur throughout the histories of a number of patients. Even if several patterns of events recur throughout a number of histories of patients, however, this does not guarantee that we will be able to attach the proper significance to them, or be able to tell what etiological part they play in an illness. But the point is that we do not yet know what events might occur or recur, and it is for these things we must first seek.

It is the purpose of this study, therefore, to determine whether, to what degree, and in what order certain variables appear in a sample of psychopathological patients—these variables being ones which have been mentioned by one author or another as being etiologically significant or have been chanced upon by the present writer.

B. Research Population

The population used in this experiment consists of three groups of patients who have received at least three months' psychiatric treatment. Each group is composed of 25 adult white females. One group of 25 is composed of phobic patients, i.e., women whose presenting complaint upon admission to treatment was

[1] Submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, in the faculty of Philosophy and Psychology, University of Tennessee, 1952.

an abnormal fear reaction. It should be mentioned that all phobic patients were agoraphobics. They were afraid to go out on the streets alone and many were afraid to remain at home alone. Do all phobics eventually become agoraphobics, or are all phobics who come to psychiatrists for help agoraphobics, or is this a selected sample? This question cannot be answered at this time any more than the obvious question which arises—are only females phobic, or are all female phobic patients married? This study is not in a position to make a valid reply to either question, but the literature which was consulted reveals few cases of unmarried female phobics or of male phobics. The second group is composed of patients who, after the prescribed three months of treatment or longer, were given a diagnosis of conversion hysteria; and the third is composed of patients whose diagnosis, after three or more months, was anxiety neurosis. The "Summary of Research Population" presents the patients used in this study.

SUMMARY OF RESEARCH POPULATION

Diagnosis	*N*	Mean Age	Marital Status
Phobia	25	30.92	100% married
Anxiety Neurosis	25	32.48	92% married 4% widowed 4% separated
Conversion Hysteria	25	31.80	88% married 4% widowed 4% separated 4% divorced

The case histories of these 75 patients were secured from psychiatrists in private practice, in federal agencies, and in city and state institutions. The case histories included psychiatric, psychological, and physical examinations in addition to neurological evaluations and, in certain instances, laboratory work or operative procedures. In addition to the intake interviews—some of which were made by psychiatrists, some by social workers, and still others by psychologists—there were notes made by the therapist during the course of treatment. Obviously, no two histories contained the same factual material, nor was the material in any particular order. In other words, the "case history" of each patient consisted of her "file" just as it was lifted out of a filing drawer, with no rearrangements, summarization, or shifting of material therein. Physicians were simply asked if they would release a "file *in toto*" on any patients they might have whose diagnosis was "phobia," "anxiety neurosis," or "conversion hysteria," without disturbing the material in any way. They were told that the material would be kept highly confidential except for the fact that a person unacquainted with any of the patients would read the file to make certain judgments, and that the person doing this would probably be a physician. It was further indicated that as soon as the judgments had been made, the file would be returned intact. Sample abstracts of the case histories of three phobic patients may be seen in Appendix A.[2]

C. Design and Procedure

The case histories previously mentioned were gathered for the purpose of

[2] Complete case abstracts and ratings are available in Webster, A. S., The development of phobias in women. Unpublished doctoral dissertation, Univer. of Tennessee Library, 1952.

having judgments made concerning them. Therefore, a rating scale was devised (see Appendix B) which would enable a rater to estimate the degree of presence or absence (Quite Marked, Moderate, Barely Noticeable, Not Present) and the order of appearance of the following points concerning the patients:

1. A father figure and his behavioral characteristics, i.e., the physical or emotional presence or absence of a male figure whose personality picture is adequate or inadequate, and its type.

2. A pattern of dominant overprotection by the mother; i.e., the bestowal of much affection on the child when good, and the withdrawal or threatened withdrawal of it when the child is bad.

3. Marriage to an older man; i.e., the number of years by which the husband's age exceeds the patient's.

4. The husband's behavioral characteristics; i.e., the adequacy or inadequacy of his personality and its type.

5. Castration and/or castration fear; i.e., the symbolic fear or surgical castration procedures.

6. Pregnancy and the rejecting of it; i.e., actual childbirth or its antecedent manifestations which are on an organic basis, and the actual or symbolic rejection of such a condition.

7. Frigidity; i.e., the amount of warmth shown by the patient toward her husband.

8. The husband's withdrawal; i.e., departure, threatened departure, or emotional withdrawal.

In order to ensure reliability, two judges were employed to make the judgments and one of the judges, after an interval of several months, repeated his judgments. The first judge, an obstetrician-gynecologist with psychiatric training, was informed of nothing concerning the investigation other than the fact that he would have to make judgments from case history material sent to him, that he had to make up his own subjective norms for each of the points on the rating sheet and use the same norms in judging each case, and that he should then write out as clearly as he could the norms which he had used in making his evaluations. Since the material sent to him contained *all* of the available material concerning the patient, obviously the diagnostic labels were also contained in the material. For this reason, so that no bias could develop if it chanced that he received several files on the same type of patient, the 75 cases were arranged according to a table of random numbers and sent to him in this order. The norms which this first judge used were then given to the second judge a year later in order that he might use approximately the same judgmental norms. The second judge, however, did not have the entire case material on which to make his judgments, but only the abstracts made by the writer, three of which appear in Appendix A. (Obviously, it was impossible to keep the case histories a year; after they had been returned by the first judge, an abstract was made of each case and the original material returned.) Considering this point in the procedure, if, when both intrarater reliability (reliability between Judge 1 and himself after making judgments of the same material several months apart) and interrater reliability (reliability between Judge 1 and Judge 2) were computed, the reliability coefficients approached each other numerically, the use of abstracts rather than the full case material would be indicated, with a marked economy of time for the person reading the material in order to make the judgments.

Judge 2 was a third-year graduate student in clinical psychology. The norms

were supplied to him, with particular emphasis upon the fact that he was to use the same norms as those arrived at by Judge 1. These norms were as follows and will be referred to hereafter as "variables," corresponding to the numbers given below:

1. *Father Figure*

Quite Marked—The patient's father must have been a salesman, buyer, or had some similar employment which required him to be absent from the home an average of four nights a week; or should be an alcoholic, gambler, faithless to his wife, and rejecting of the children.

Moderate—The patient's father may have been employed in any of the activities mentioned above but been absent from home only 2-3 nights a week and should seem from the case history to be "fairly adequate" as a father and husband.

2. *Dominant Overprotection*

Quite Marked—The patient's mother should be most solicitous of the child's welfare, rewarding her often without good reason, and rejecting or threatening to reject her or actually telling her she would not love her any more if she did not "behave."

Moderate—The patient's mother should do the above-mentioned activities, but to such a degree that it is mentioned by only one or two persons in the statements compiled in the folder.

3. *Marriage to an Older Man*

Quite Marked—The patient should have married a man seven or more years older than herself.

Moderate—The patient should have married a man 4-6 years older than herself.

4. *Castration and/or Castration Fear*

Quite Marked—The patient should have had a panhysterectomy, subtotal hysterectomy, partial hysterectomy, or a bilateral salpingectomy.

Moderate—The patient should have had a unilateral salpingectomy or many dreams of pursuit in which she was the pursued party, while the pursuing party carried some sharp object and meant her harm—guns are not acceptable, nor are sticks, rocks, or any form of club. The patient may also be obsessed with the idea of not going to sleep unless all of her limbs are covered with a sheet or blanket or unless all objects on her dresser are arranged so that she feels there is no danger of anything falling off.

5. *Pregnancy and its Rejection*

Quite Marked—The patient's actual statement that she did not wish to become pregnant; attempts at abortion, suicide, or self-maiming.

Moderate—Deep depression on the part of the patient during pregnancy, and statements of persons other than the patient concerning her dislike for being pregnant.

6. *Frigidity*

Quite Marked—The patient's actual statement that she is frigid and dislikes her husband.

Moderate—The patient's husband states that she is frigid.

7. *Husband's Withdrawal*

Quite Marked—Actual separation, initiated by the husband; or continual threatening of separation on his part, or extreme emotional aloofness from the patient.

Moderate—Occasional threatening of the husband to separate from, divorce, or otherwise leave the patient; or poor emotional relationship between the patient and her husband.

8. & 9. *Other Characteristics of Patient's Father and Husband*

The other characteristics of the patient's father (8) and husband (9) are in terms of diagnostic categories and the appropriate classification is made depending upon the history of either given. Thus a description of a shy, withdrawn individual would be "schizoid," while a faithless, alcoholic gambler would be termed "psychopathic," etc.

These norms will be further discussed in a section concerning the limitations of this design.

Thus, judgments were made on the same set of randomly presented material by two judges using approximately the same norms, although it must be remembered that the second judge used only abstracts instead of the full case material.

This study was not amenable to elaborate statistical analysis, primarily because there is no known instrument which would accurately measure that which this study considers. For this reason, statistical techniques are purely for descriptive and summarization purposes. For such purposes, the methods of percentages and chi square were employed to determine whether there were significant differences between the pho-

bic group and each of the other two groups in terms of number of symptoms present and the intensity of such symptoms.

D. Limitations of the Design

It is obvious that the norms used in this study are subjective. The first judge was not even able to list those events in the case history which would lead him to a judgment of "Barely Noticeable." It might be argued that, even though he had difficulty in expressing those factors which led him to his judgments, if he and the second judge arrived at the same judgments, then however poor the norms may be, they actually enabled two people to arrive at the same conclusions. This is not a valid point, however, since many people, if trained in similar fashion, might arrive at the same conclusions with poor norms, while were the norms more adequate, they might have arrived at different conclusions. In any case, this inadequacy with respect to norms should be recognized; it simply points out that a weakness in quantification is inherent in the nature of this study.

It is also to be noted that the groups are unmatched in variables which may be significant, although it is assumed that randomization minimizes this weakness.

Finally, it should be mentioned that the design is not practical—judging by the fact that the first judge, utilizing case history material *in toto*, took over 160 hours. This weakness could be offset if it were found that abstracts could serve the same purpose with as great reliability as the entire case record.

III. RESULTS

A. Reliability of Ratings

Reliability coefficients were computed between the first and second ratings of Judge 1, and the first ratings of Judge 1 and those of Judge 2. These were product-moment correlations with Sheppard's correction. Contingency coefficients were also computed for the comparison of judgments between the diagnoses for the "other characteristics of father and husband." For statistical purposes, any diagnosis other than "normal" was considered "unstable." Since there is only a twofold division, some statistic is needed to compare stable vs. unstable, and thus a contingency coefficient was chosen. The three groups of patients will be hereafter referred to as P, CH, and AN for the phobic, conversion hysteric, and anxiety neurotic, respectively. Table 1 presents the coefficients computed. It is to be noted that the maximum contingency coefficient possible with a fourfold table is .866. In the case of "marriage to an older man," the ratings were identical for all three judgments. Thus no reliability coefficient could be computed.

Since the interrater correlations are quite high, we need employ only one judge's set of ratings in computing the significance of differences between the three groups with respect to variables 1-9, described previously. Therefore, only the first ratings of Judge 1 will be used in the computations to follow.

B. Ratings Obtained of Individual Variables

Tables 2–8 are divided into two parts, one of which shows the percentage of occurrence of each variable for the groups. The other part shows the chi squares and level of significance at which we can assume that these are not chance

TABLE 1

OVER-ALL RELIABILITY COEFFICIENTS

Variable	Intrarater	Interrater	p
	Correlation Coefficients		
1. Father figure	.92	.91	.01
2. Dominant overprotection	.92	.91	.01
3. Marriage to an older man	—	—	—
4. Castration	.97	.93	.01
5. Rejection of pregnancy	.88	.86	.01
6. Frigidity	.88	.87	.01
7. Husband's withdrawal	.88	.86	.01
	Contingency Coefficients		
8. Husband's characteristics	.83	.80	.01
9. Father's characteristics	.82	.80	.01

TABLE 2

INCIDENCE OF LACK OF AN ADEQUATE FATHER FIGURE

Group	% Incidence	Incidence/ Total	Comparison	χ^2	df	p
P	100	25/25	P-AN	12.042	1	.001
AN	52	13/25	P-CH	10.386	1	.001
CH	56	14/25				

results. The chi squares were computed with Yates's correction from combining the categories "Quite Marked" and "Moderate," as opposed to the combined categories "Barely Noticeable" and "Not Present." Even though it can be seen that in the latter categories there was some "presence" of the variable, to the extent that it was noticeable, for the sake of statistical expediency the two gross categorizations were so set up. The same methods of combination and computation hold true for the remainder of the tables in this section, so it can be seen that whenever a column is labeled "% Present," it means present to a "Quite Marked" or "Moderate" degree.

1. *Lack of an adequate father figure.* The indications are that patients in the P group show a significantly greater tendency toward lacking an adequate father figure than does either of the other two groups.

2. *Dominant overprotection.* The indications are that patients in the P group show a significantly greater tendency

TABLE 3

PRESENCE OF DOMINANT OVERPROTECTION

Group	% Present	Presence/ Total	Comparison	χ^2	df	p
P	96	24/25	P-AN	13.714	1	.001
AN	44	11/25	P-CH	13.714	1	.001
CH	44	11/25				

TABLE 4

PRESENCE OF MARRIAGE TO AN OLDER MAN

Group	% Present	Presence/ Total	Comparison	χ^2	*df*	*p*
P	56	14/25				
			P-AN	1.288	1	Not significant
AN	36	9/25				
			P-CH	1.288	1	Not significant
CH	36	9/25				

TABLE 5

PRESENCE OF CASTRATION OR CASTRATION FEAR

Group	% Present	Presence/ Total	Comparison	χ^2	*df*	*p*
P	92	23/25				
			P-AN	25.961	1	.001
AN	12	3/25				
			P-CH	16.638	1	.001
CH	32	8/25				

toward having experienced dominant overprotection on the part of the mother than does either of the other two groups.

3. *Marriage to an older man.* The indications are that marriage to an older man occurs no more often in any one of the three groups than it does in either of the other two.

4. *Castration or castration fear.* The indications are that patients in the P group show a significantly greater tendency toward having experienced castration or castration fear than does either of the other two groups.

5. *Rejection of pregnancy.* The indications are that patients in the P group show a significantly greater tendency toward having rejected pregnancy than do patients in either of the other two groups.

6. *Frigidity.* The indications in the case of this variable are that the P group shows a significantly greater tendency toward being frigid than does the CH group, but it is questionable whether an adequate differentiation may be made between them and the AN group.

7. *Husband's withdrawal.* The indications are that the husbands of patients in the P group show a significantly greater tendency toward withdrawal from the patients than do husbands of patients in either of the other two groups.

8. *Other characteristics of the husband.* In this table, as in Table 1, the

TABLE 6

PRESENCE OF REJECTION OF PREGNANCY

Group	% Present	Presence/ Total	Comparison	χ^2	*df*	*p*
P	92	23/25				
			P-AN	13.220	1	.001
AN	36	9/25				
			P-CH	25.961	1	.001
CH	12	3/25				

TABLE 7

PRESENCE OF FRIGIDITY

Group	% Present	Presence/ Total	Comparison	χ^2	*df*	*p*
P	92	23/25	P-AN	1.780	1	.20
AN	64	16/25	P-CH	9.191	1	.01
CH	44	11/25				

terms *normal* and *unstable* are applied to the judgments made. Table 9 additionally presents a breakdown into nosological categories of the percentages of occurrence in the opinion of the rater.

The indications are that the husbands of patients in the P group show a significantly greater tendency to be unstable or inadequate than do the husbands of patients in either of the other two groups.

9. *Other Characteristics of the Father.* The presentation of this table is identical with that of Table 9.

The indications are that the fathers of the patients in the P group show a significantly greater tendency to be unstable or inadequate than do the fathers of patients in either of the other two groups. It may seem at first glance that these tables (Tables 9 and 10) present incredible percentages, but it must be mentioned again that *descriptive* terms only were used.

It requires mention that in five instances in the P group, three instances in the CH, and six instances in the AN group, there was insufficient information from which to make a judgment. Therefore, in the computations of the percentages and chi squares, these omissions were duly noted and the *N* for the particular variable under consideration was reduced by the appropriate number. In

TABLE 8

PRESENCE OF HUSBAND'S WITHDRAWAL

Group	% Present	Presence/ Total	Comparison	χ^2	*df*	*p*
P	100	25/25	P-AN	26.775	1	.001
AN	24	6/25	P-CH	8.82	1	.01
CH	60	15/25				

TABLE 9

PRESENCE OF AN UNSTABLE HUSBAND

Group	% Present	Groups	χ^2	*df*	*p*
P*	96	P-AN-CH	43.315	4	.001
AN**	8	P-AN	35.336	1	.001
CH†	8	P-CH	35.336	1	.001

* 92% of these men were adjudged psychopathic, 4% neurotic, and 4% normal.
** 88% of these men were adjudged normal and 12% psychopathic.
† 88% of these men were adjudged normal and 12% psychopathic.

TABLE 10

PRESENCE OF AN UNSTABLE FATHER

Group	% Present	Groups	χ^2	df	p
P*	96	P-AN-CH	39.511	4	.001
AN**	16	P-AN	35.562	1	.001
CH†	20	P-CH	26.000	1	.001

* 87.5% of these men were adjudged psychopathic, 8.3% schizophrenic, and 4.1% normal.
** 81.8% of these men were adjudged normal, 13.6% psychopathic, and 4.5% schizophrenic.
† 75% of these men were adjudged normal, 20% psychopathic, and 5% schizophrenic.

no patient's case, however, were more than two judgments omitted by the rater, and these omissions occurred on only on one occasion; the remainder of the single omissions were widely scattered.

C. ANALYSIS OF SEQUENCES OF VARIABLES

Table 11 was constructed to show the percentage of times that one varible appears in the record prior to others. This table is incomplete since some variables cannot make their appearance prior to the occurrence of others (rejection of pregnancy cannot appear prior to marriage) and also because only those percentages which, by inspection, appeared large, were computed. The remaining two groups (CH and AN), excluding those variables which cannot occur prior to the occurrence of another, show percentages ranging only in the twenties, with the exception of lack of an adequate father figure, which precedes dominant overprotection 92 per cent of the time in the case of the AN group, and 84 per cent of the time in the case of the CH group. In only three instances could judgments as to the order of precedence not be made in the P group (because of incompleteness of the record), while there are 78 such instances in the AN group and 86 in group CH.

TABLE 11

ANALYSIS OF SEQUENCES FOR GROUP AH

Lack of an adequate father figure precedes dominant overprotection 100% of the time
Rejection of pregnancy precedes castration or castration fear 65% of the time
Frigidity precedes rejection of pregnancy 91% of the time
Frigidity precedes husband's withdrawal 70% of the time
Frigidity precedes castration or castration fear 48% of the time

Table 11 indicates some fairly well-regularized relations in the P group, most notable of which is that lack of an adequate father figure occurs before dominant overprotection on all occasions. This occurs frequently, however, in both of the other groups. The remaining four percentages shown indicate a trend toward being present in the P group. No such trend is apparent in either of the other two groups.

It should be noted that all patients in the P group were judged as possessing to some degree all of the traits of the variables under consideration. Those instances which lead to percentages lower than 100 are possibly due to insufficient information for making a judgment. If those instances in which there was an insufficient amount of information given to make a judgment were discarded and the "Barely Noticeable" category were included in the percentage computations, all the patients would have shown presence of all the variables, with the excep-

tion of marriage to an older man. Statistical expediency, however, dictated that the "Barely Noticeable" category should not be included.

A final addendum should be made concerning the results found. This concerns one additional statistical procedure —a chi square representing a finding which did not appear, and which was not suspected, until the results of the judgments were in. On the judgment sheet, as shown in Appendix B, there is a space for the judge's observation as to whether any other variables occur which he feels to be of importance in the case history. A number of symptoms were observed by the judge and placed in these spaces, but the one which occurs with great frequency is "exposure to therapist"—that is, the patient in some way exposes her breasts, legs, or genitalia to the person treating her. This was noted in 18 of the 25 phobic cases, in one case of anxiety neurosis, and in two cases of conversion hysteria. Among the three groups for exposure to therapist, the chi square was 93.381. This is significant at the .001 level, indicating it appears likely at a very high degree of confidence that the finding is a real one. Thus, the fact that exposure to the therapist occurs a significantly greater proportion of the time in the P group as compared to the other two groups does not seem to be an artifact. It should be noted, however, that the judge may not have noted with equal emphasis the presence or absence of this symptom in all cases, although it must be remembered that this chi square represents only the first judgments of Judge 1, and also that the cases were presented to him in random order. Nevertheless, it must be regarded more tenuously than the other chi-square findings. Expressed in terms of percentages: (*a*) 24 per cent of the P group "exposed" themselves to the therapist as compared with 1.3 per cent of the CH group; (*b*) 9.3 per cent of the P group did not "expose" themselves to the therapist as opposed to 32 per cent of the AN group and 30.6 per cent of the CH group.

IV. DISCUSSION

The results shown in the preceding section should be considered as tentative and preliminary to further research. Therefore, it should be borne in mind that to say that the findings have differentiated phobias (anxiety hysteria) from anxiety neuroses and conversion hysteria, or that it is concluded that we have differentiated anxiety hysteria from anxiety neuroses and conversion hysteria is to say little, since this is accomplished in the presenting complaints. One of the prime reasons for the dearth of research in the phobic field is that the diagnosis is immediately established. It seems, however, that something more than differentiating by virtue of diagnosis has been accomplished. In these cases, a differentiation has been made on the basis of the occurrence of certain variables, so that, even in the absence of knowledge of presenting complaints or of the diagnosis, the existence of a phobia could be deduced. Such a condition exists at least in the cases presented in this study.

The results indicate quite clearly that lack of an adequate father figure, dominant overprotection by the mother, inadequacy of the patient's husband, castration or castration fear, the rejection of pregnancy, frigidity, and the husband's withdrawal regularly occur in these phobic women. Does this mean that they are causal factors? If they were

not, why did they not appear with equal frequency or strength among the patients who did not have phobias? There is every statistical and clinical indication that such occurrence is not on the basis of chance. It cannot be argued, for example, that the variables might be the result of the phobia rather than a cause, since they do not occur temporally after the development.

Clinically, the phobic patient presents too many of the combined symptoms of both anxiety neurosis and conversion hysteria to justfy the view that these three syndromes come from totally different universes. Yet they appear quite different in this study. This is due to the fact that particular variables are causal factors in the development of the phobia—which cannot develop without them—while they simply contribute to the general situation in the other two groups. Thus, the clinical appearance of combined symptoms in the phobic, from both anxiety neurosis and conversion hysteria, can be reconciled with the statistical appearance of disparate variables in the phobic group as compared with each of the other two groups.

The variables used in this study have been referred to as "variables" rather than "events" in a life history because they have appeared with such regularity in phobic cases other than those used in this study, while the term "event" implies a happening which may or may not be of importance. Thus, "variable" is used advisedly to indicate a happening of some particular importance. The variables used in the present study are also found in almost all other case histories relating to female phobias, but they have been almost universally ignored. The chief reason for this neglect seems to be that the facts are isolated, apparently have little superficial relation to each other, and are either buried in seemingly more important facts, or in esoteric terminology. When these variables do not appear, it is usually a result of insufficient information, poor history-taking methods, or bias on the part of the examiner. It might be argued that it is easy to explain away anything by saying that there is insufficient information given to determine whether or not a symptom is present. This is a valid objection. The facts in this case, however, do not support such a contention, since in all cases if the possibility of existing were present, the variable itself was present—that is to say, in no cases where there was sufficient information given to make a judgment was a variable absent. Allowing for the "insufficient information" factor, *all* variables were present in *all* cases, disregarding "marriage to an older man."

If they are causal, what relation can these variables have to the development of phobic reactions in women? The hypothesized relationship is that in the absence of a father figure, the patient develops ambivalent feelings toward the mother because of her dominant overprotection, which generally causes anxiety and feelings of insecurity—that is, the patient is unable to develop her potentialities, to experience the capacity for self-realization. Yet the anxiety and ambivalent feelings toward the mother figure push the patient to leave the mother. She does this in socially acceptable fashion, however, by marrying. It is felt that she chooses an inadequate person both because of desire to displease the mother and inability to choose wisely because of the restrictions which have been placed on her by the mother; i.e., her dependency on the mother precludes opportunity for wide experience. The patient is frigid because of immaturity

and because of fear of pregnancy for which she is totally unequipped. She herself wishes to be dependent, so it can hardly be expected that she can permit someone else to be dependent upon her. Nor is her husband adequate for her dependency needs, which is one of his reasons for leaving the patient. That is, the husband, originally a "weakling," who himself needs someone upon whom he can be dependent, finds out that not only is his wife not such a person, but also that she has robbed him of his manhood by not wishing to have a child.

Castration is here conceived of not necessarily as a hysterectomy, but as any act which deeply traumatizes the patient. The persons who are insecure are fearful of being hurt. It is for this reason that they develop the phobia, literally in order to protect themselves. They wish to be dependent and perhaps also to keep the husband near them to satisfy their dependency needs. These acts, however, if they have not already alienated the husband, will do so soon—being unable to cope with a person more sick than himself, he will leave.

Many authors have conceived of castration as playing an important part in the development of anxiety hysteria or phobias. Yet, from the results of this study it does not seem more important than the other symptoms cited; it seems to be simply one link in a chain of events, all links of which must be present before the chain is complete. It is felt, however, that castration may be the genotype for a variety of events; that it may have other forms than surgical castration; and that if all other symptoms deemed necessary to the development of the phobia save castration are present, any severe trauma to the patient's self-conceptualization may cause a phobia to develop. This point will be discussed further.

The list of variables compiled throws light on the reason for the great difficulty in extinguishing the phobia. None of the variables except those pertaining to the husband is reversible. That is, lack of an adequate father figure, dominant overprotection, and castration are irreversible phenomena. The husband's leaving, his behavioral characteristics, and the patient's frigidity and rejection of pregnancy (the last only if castration is not complete) can conceivably be reversed or changed and thus break the chain of symptoms leading to the phobia.

Thus, *the husband's position can hardly be overestimated since he provides the only link in the chain which can be attacked.* Clinically, this is fairly easily accomplished since the husband himself is immature, has suffered a blow to his ego, and would like to have someone on whom he can be dependent, even more now than prior to his wife's development of the phobia. The person upon whom he can feel dependent is quite conceivably a therapist. In most instances, however, the husband is hostile toward his wife's therapist for "stealing" her from him, and so impugns the therapist vehemently. If this is not enough, he must admit his failure to manipulate his own life. If he can be gotten to come for interviews to a therapist other than his wife's therapist, there is much less conflict and his dependency needs can more easily be satisfied in the presence of one who knows nothing of him than with one who is familiar with his circumstances. It is interesting to note that in this study only those patients whose husbands came for treatment showed any degree of improvement at the time their case history was secured. The point cannot be overemphasized that the husband is the therapist's only means of entrance into a closed and self-sustaining system.

The final point to be made involves a question which one asks oneself after seeing the results of this study—do only those female patients who present the variables enumerated develop phobias?

The answer to the question is a difficult one in view of the fact that (apart from those cases where no judgment could be made) all patients presented all variables cited except marriage to an older man. It seems likely, however, that patients can develop phobias as a result of one tremendously severe trauma or several sequentially similar traumas. Such phobias, however, dissipate independently over a fairly short period of time or quite quickly with psychotherapy, in contrast to the phobias cited in this study, and generally are based upon a quite realistic fear or generalization of some realistic fear. Moreover, at this point we can see that phobias may not really be irrational fears at all, nor intense fear-produced responses of childhood, nor illogical fears. If full account is taken of the various factors present in each case of phobia, there is every reason to hope that, with further research, a definite causal sequence can be established to remove the last doubt that these manifestations are not irrational or illogical fears.

V. SUMMARY AND CONCLUSIONS

This study was undertaken with the hope that the results might cast some light on the etiological factors involved in the development of phobias in married women.

Three groups of white female patients were selected. Each group of 25 patients was comprised of married women with the same diagnostic label. One group was composed of phobics, one of anxiety neurotics, and one of conversion hysterics. These patients had received a minimum of three month's psychotherapy. The case history of each of the patients was secured. Each case history contained medical, psychiatric, psychological, and, in some cases, neurological reports and operative procedures. A rating sheet was devised in order to permit a judge to rate the order of appearance of certain variables, together with their intensity. Those points to be judged were presence or absence of: an adequate father figure, dominant overprotection by the mother, marriage to an older man, castration of the patient, frigidity of the patient, rejection of pregnancy by the patient, departure or threatened departure on the part of the husband, adequacy of the husband. Rating sheets and randomly ordered case histories were presented to a judge for the purpose of making such ratings and enumerating any other factors he considered of importance. Several months later he was again required to make the same judgments. One year later abstracts of the cases were presented to a second judge together with rating sheets in order that he might also make judgments. Statistical analysis of the data by means of chi square and percentages was undertaken to determine the significance of the relationship of the variables to the three groups of patients. Further statistical analysis was undertaken to establish the reliability of the three sets of judgments. For this purpose Pearson product-moment correlations and contingency coefficients were employed. A presentation of the findings was followed by a discussion of the results and implications of this study, together with a proposed explanation of the importance of the variables for development of phobias.

From this study it is concluded that

the variables under consideration—namely, (*a*) lack of an adequate father figure, (*b*) dominant overprotection by the mother, (*c*) castration or castration fear, (*d*) frigidity, (*e*) rejection of pregnancy, and (*f*) the fact that the husband, an inadequate individual, leaves or threatens to leave the patient—play an important etiological part in the development of a phobic syndrome, and that such variables are not etiologically significant in the cases of anxiety neurosis and conversion hysteria which were used in ths study. One of the points, marriage to an older man, appears to be of no value whatsoever in differentiating among the groups.

The occurrence of these variables seems to be moderately systematized in the case of the phobia group, with lack of an adequate father figure occurring prior to dominant overprotection, which in turn precedes marriage to an older man. This is then followed by husband leaves, then by either frigidity or castration, and finally by rejection of pregnancy. In the case of the other two groups, no pattern of precedence of any type is shown.

Further, it is concluded that abstracts of case histories may be used instead of full case history data for making judgments of the type involved in the rating sheet designed for this study, thus effecting a major saving in time expended by the judge. The rating sheet appears to be reliable for use in further research when used in conjunction with the norms cited in the body of this study.

Treatment of the husband of the patient concurrently with the wife's own treatment seems to be the most efficacious manner of securing a remission of the phobic symptoms.

In addition to the points under consideration, it appears that phobic patients, in significantly greater proportion than patients in either of the other two groups, expose themselves sexually to the therapist. Over 90 per cent of both the husbands and fathers of the patients in the phobic group appear to have been psychopathic.

An implication drawn from this study is that time and effort may be saved by employing abstracts of case histories rather than the full history itself—that is, since the reliability between judgments is high, considering that full case histories were used in one instance and only abstracts in the second case, the abstracts are almost as useful in making judgments as the full material.

APPENDIX A

Illustrative Case Studies

Case 1

The patient is a white female, age 30. Her father, age 56, is a physician. Her mother is age 52. Her husband is age 32 and a minor executive of a railroad manufacturing concern. The patient and her husband have two children, both of whom are girls, ages 5½ years and 18 months. The patient was referred by her father after having visited a number of other psychiatrists. The presenting complaint was the inability of the patient to remain alone, both at home and primarily when away from home. Her greatest fear is being on the street alone. The patient is afraid of driving the car alone. She has no fear when her children, or her husband, or a relative is with her to drive the car or to go down town. Her present illness began during the first month of her first pregnancy. At this time she was very much afraid to be alone and, moreover, was "petrified" for fear of what would happen to her for having the baby. When the first baby was three months old, the patient's father and mother went on a vacation, and the patient felt that she was being "pushed out of the house."

It was during their absence that her symptoms became full-blown, and have remained for a little over six years now. The patient's mother states that her own life since marriage has not been a happy one because of her husband's drinking, gambling, and philandering. She stated that he was rarely home, and when home, he paid little or no attention to the child (the patient). On occasion he would bring her a magnificent present. The patient's father states that he was unable to remain in his home because of his wife's nagging. He stated that she spoiled and pampered the child, dominating her tremendously. The patient's husband states that the patient tries to boss him too much, nags him continually, and that their sex life is not satisfactory. He states that she "lies on the bed like a rock" when they have intercourse. He feels that her illness is either imaginary or a deliberate attempt to gain sympathy. Prior to the beginning of her illness, he threatened to divorce the patient unless she became a better wife. The patient's husband leaves the house about 7:00 o'clock in the morning and returns to the house about 6:30 in the evening. However, many evenings he is required to work until 10:00 or 11:00 o'clock. The "working late" began during the war and has continued until the present. The husband is quite resentful of the money which has been spent on the wife in seeing psychiatrists and will himself only agree to bring the wife to the office and to take her home. On no account will he enter into a therapeutic relationship himself. The husband admits that he has drunk quite a bit, has gambled to a small extent, and has not been faithful to his wife. He states that from the time he was about 13 until recently a maternal aunt has given him five dollars on frequent occasions to have intercourse with her. He was quite resentful of being interviewed in any case and seemed to have no regret for any of his past actions. Communication with the last psychiatrist whom the patient had seen revealed that he considered her to be "quite masculine in character and resentful of any attempt to deprive her of this trait." He stated that prior to her marriage the patient had indulged in perverse sexual activity, both homosexual and heterosexual in nature. Further, that she is quite resentful of her children and the restrictions which they place on her activities. He feels that her protest against her first pregnancy was one of the factors upon which the development of the illness is dependent. The physioneurological findings are negative except for a fistula between the vagina and the rectum. Consultations with surgeons reveal that although the fistula is not inoperable, it is unlikely that repair could be successful. The patient states that flatus escapes through the vaginal opening rather than through the rectum, causing her much discomfort. The patient has, on several occasions, exposed herself to the psychiatrist and the psychologist whom she is now seeing. However, she states that on several occasions when she has had an opportunity to go walking or riding with a man other than her husband or a member of her family, she has become most fearful. The patient states that she feels she is quite like her mother and hates herself for being this way. She is quite fond of her father. Several times there has been a remission in symptoms only to have them return in full strength. Whenever there does seem to be a remission in symptoms, the husband of the patient seems to "blow up" and tells the patient that she thinks only of herself. The patient states that she "gets scared" because he sounds like "mother." This is the first marriage for both the patient and her husband. They have been married eight years. Their religious faith is the same. The patient and her husband have sexual relations about once in two months. The socioeconomic status of the patient and her husband is above average. The formal diagnosis in this case is anxiety hysteria.

Case 2

The patient is a white female, age 33. Her husband is age 42. He is a clerk in a small combination beer garden and store. It is the patient's first marriage and the husband's third. The husband has no children from either of his previous marriages. The patient and her husband have no children. The patient had a bilateral salpingectomy at age 21. Her present illness began with nervousness six years ago and her presenting complaint was fear of being alone and particularly of going out on the street alone, which began two years ago. The intensity of this fear varies from time to time. She was able to work for about eight months after her "fear" symptoms began, and then had to quit her job because she was unable to go to work alone. When she attempts to go on the street alone, she complains of vertigo, syncope, palpitation, and perspiration. The patient is quite aggressive and states that she has fears of homosexuality. She feels these fears were partly related to homosexual experiences in which she participated during her adolescent years. She stated that in her early teens she hated men and decided never to get married, but that in her late teens she had several affairs with married men. They seemed more attractive to her because of their seriousness. She considered men of her own age as "silly and mushy." The patient was a telephone operator until she could no longer work because of her symptoms. The patient's father died when she was 17. The patient's mother has been living with them since their

marriage. The patient states that her husband was quite intolerant of her illness and used to rant and rave because of it. She states that he is a drunkard and that she doesn't trust him. The patient's mother is very religious and quarrels with the patient and her husband because they go out and the mother will pout and isolate herself from the patient. The patient's mother states that she and the patient's father never got along well and that he was not faithful to her because he drank and because he gambled. The patient states that her husband also gambles. Her husband consented to bring her to a psychiatrist (having been referred by Johns Hopkins Clinic) only because he thought that after one visit she would be cured. They have many arguments about the need for a long-range program of treatment. Actually, she has spent over a thousand dollars on treatment and the husband is most resentful of this. He has threatened to leave on several occasions and storms out of the house and later comes back. The patient's husband says that she is too cool and too selfish. He calls her a Virginia Blueblood or Queen So-and-So. He is resentful of her spending money on clothes, particularly since she is tall and has to have most of her clothes made. He feels that he has to keep moving all the time. He states further that his wife is the "frigid beast." The patient states that the husband is a real "heller." The patient's husband states that he resents the mother-in-law living with them very much because he feels that she has more influence on the patient than he does. The patient feels that she must be two jumps ahead of everybody. She feels that people are not to be trusted. She feels very anxious. She does try to go out of the house and see the man on the street. On several occasions there has been a partial remission of symptoms, but as soon as the patient gets better, her husband becomes very aggressive toward her and she relapses. Both of them feel that they cannot discuss things without ending up in an argument. The patient began having homosexual and heterosexual relations at age 14. The patient states that her father was an alcoholic and was unfaithful to her mother. The patient's husband resents her knitting or reading or doing anything alone. The patient states, "I've always resented men deeply because of father's behavior." The patient becomes very nervous when she attempts to have intercourse with her husband and thinks that it is very unsatisfactory for her. She feels very resentful of her mother living with her and her husband. She feels that her mother has always tried to "boss" her too much and has pouted if she could not get her own way. Communication with the psychiatrist whom she saw at Johns Hopkins revealed that, "she seems to have confused her masculine and feminine identification and in many respects is somewhat masculine. She is resentful of male aggression." Her husband has no church affiliations and their socioeconomic status is below average, although the patient came from a wealthy family. The father of the patient was rarely at home before he died. The physioneurological examination is negative except for a low metabolic rate which is being corrected with thyroid extract. The formal diagnosis in this case is anxiety hysteria.

Case 3

The patient is a white female, age 30. The husband is age 33. It is the first marriage for both. They have one son, age 4. The patient's present illness began when her son was six months old. The boy became ill with a throat infection and the patient's husband was away at the time. She suddenly became nervous, began to tremble, and within a week her fear of being alone and going out on the street alone developed to an acute stage. The patient states that she had a great deal of anxiety when she was pregnant because she didn't know if she would be able to care for a baby. She had a very long labor and gained 15 pounds during the pregnancy. The patient's mother came to help her, but was highly nervous and more hindrance than help. The patient states that she never wanted a baby and did not want the responsibility of having one. The patient's mother stayed until the baby was two months old. The patient states that she has been completely frigid since her marriage, but was not so before her marriage. She states that she has no interest in sexual relations and that they rarely have them. When the patient was in her teens, she learned that her father had had a mistress since she was five years old. The patient's father told her that he wanted to have a good time and the patient's mother wanted a nice home and to raise her children; therefore, if he had a mistress, both he and his wife would be satisfied. The patient's father would usually come in late after the patient had gone to bed so that she rarely saw him. The patient says that she had more respect for her mother than for her father, although she was fond of her father and felt sorry for him because the patient's mother nagged him so much. She states that her mother nags her and acts very much like a martyr when the patient does not do what she wants. The patient's husband is the manager of a shoe store. He goes to New York on buying trips from three to four times a year. She has suspected him of being with another woman, but has never been able to prove it or to get him to admit it. As the patient got older, she realized that her parents didn't get along and thought that sex might have something to do with it, and was

determined not to have the same trouble in her own marriage. Although she indulged in both homosexual and heterosexual play in her teens, she states that she was a virgin at the time of her marriage and that she knew more and had read more about sex than her husband. The patient's husband told her that she was abnormal because she had no orgasm. They began arguing shortly before the baby was born. The patient did not want to have a baby, nor had they planned to do so, although the husband wanted one. He states that perhaps it became too important to him. He has told her that he would like to go back into the army because he is unhappy at home. He says that while he was in the army, he lost his "niceness" for a while. He says that he did expect more of his wife after the baby was born, but got less. He says that she didn't seem glad to see him when he came home at night and that she spent a great deal of money. The patient states that the baby is too great a responsibility, that she never wanted the child and now she has to do all the baby's things by hand, get the groceries, and work around the house. The patient feels that their sexual relations can never work out and can never bring her happiness. She states that she is somewhat frigid now. She is fearful of being homosexual. She is quite fearful of her husband's being unfaithful. She wonders if her husband lies to her. Both the patient and her husband blame each other for their poor sexual relations. The patient's husband suffers from premature ejaculation. She feels that she has become almost totally frigid since the birth of the child. The patient's husband admits that he has not been an "angel" since the marriage. The patient's husband is quite resentful toward the patient's mother and does not like for her to visit them because he feels that the patient is both fearful of her and dominated by her. The patient admits that she is dominated by her mother to a great extent when she is around her. The patient says that she is somewhat fearful of her husband. She states that she feels aggressive toward both her husband and her mother and feels quite guilty and fearful because of it. She states that "if he (the husband) is unfaithful, it is because I have rejected him." She feels that his business trips have increased in the last few years and that he does this on purpose so that he can get away from her. The referring physician stated that he felt that the patient had confused her identification. She is particularly confused over her relationship with her father, particularly since the father was seldom home and was quite indulgent when he was home. The patient states now that she both hates and loves her father and that she wonders if it isn't the same way with her husband. Both the patient and her husband are perfectionistic and the patient has had some compulsion since she was in her early teens. For example, she cannot go to sleep at night unless her arms are underneath the covers and she awakens at night if she happens to toss and turn and one or both arms get out from under the covers. They have sexual relations infrequently at present. The physioneurological examination was negative. Originally present complaints of syncope, asthenia and anorexia, vertigo, palpitations, and cephalalgia continue, but to a somewhat less degree than originally. The socioeconomic status of the patient and her husband is about average.

APPENDIX B

Number the manifestations which are listed below in the order of chronological occurrence as you have noted it from your observation of the material provided to you. Place an (X) in the appropriate box indicating your judgment of the depth of the manifestation, and in that same row place the statement which leads you to the conclusion that such manifestation exists in noticeable degree. If there is more than one such statement which led you to your conclusions, enter all such portions of the material. In the last two rows, specify a personality type as psychopathic, neurotic (type), schizophrenic, etc., or "No Remark," using any personality type as being purely descriptive rather than feeling that you are committing yourself to a formal diagnosis, and adding any remarks you may wish concerning the personality of the husband and father.

Case No. _____

Number	Manifestation	Depth of Manifestation			
		Quite Marked	Moderate	Barely Noticeable	Not Present
	Lack of an adequate father figure				
	Dominant overprotection				
	Marriage to an older man				
	Castration or castration fear				
	Rejection of pregnancy				
	Frigidity				
	Husband leaves				
	Other				
Behavioral characteristics of husband		State:			
Behavioral characteristics of father		State:			